WELCOME TO THE VISION CLINIC

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this in order to give you the best care possible.

Completed Welcome to the Office Form: The diagnostic information includs personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.

Please call the number on the back of your insurance card and get answers to the following questions. If we do not have this information, you will be responsible for paying us for all charges at the time of service and then seeking reimbursement from your coverage:

- Do I have vision exam coverage?
- Do I have eyeglasses or contact lens materials coverage?
- Do I have medical coverage?
- Do I have a co-payment?
- Do I need to satisfy a deductible?
- Are my Family members covered?

Eyeglasses: Please bring ALL pairs of glasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc.

Contact Lenses: It is best to wear your current contacts to your appointment if possible. It is very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacture, etc.

Dilation Explained: The doctor may need to use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at a near (reading) distance. Therefore, if you want new eyewear or feel you may need to select new eyewear, please come 15 to 20 minutes before your appointment time in order to look at our frame selection. An alternative to dilation is having an Optomap Retinal scan. This test aids in diagnosing eye diseases such as macular degeneration, glaucoma, retinal detachments, etc; but also provides a base line for future eye exams.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner.

We look forward to your visit!

VISION CLINIC

WELCOME TO OUR OFFICE

Today's Date

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Sex M F
Work Phone _____
Date of Birth _____Age _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Email Address _____

What is the major purpose of this visit?
_____
_____

Any problems with your current contact lenses or glasses?
_____
_____
_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

The mission of The Vision Clinic is to provide individual comprehensive medical and vision eye care in a friendly, caring environment. Our staff will strive to offer our valued patients personalized services and products that meet their highest expectations.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN _____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN _____
Subscriber Birth Date_____

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Burning
❑ Cataracts
❑ Corneal Abrasions
❑ Crossed eye/Eye turn
❑ Double Vision
❑ Eye Infections
❑ Eye Injury
❑ Flash of light
❑ Floaters/Spots
❑ Glaucoma
❑ Grittiness
❑ Headaches
❑ Iritis/Uveitis
❑ Itchiness
❑ Lazy Eye
❑ Macular Degeneration
❑ Occasional dryness
❑ Retinal Detachment
❑ Sunlight Sensitivity
❑ Tearing
❑ Trouble seeing at night
❑ Uncomfortable glasses
❑ Other eye disorders_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems? Please circle.
Allergies
Arthritis
Blood/Lymph
Bronchitis
Cancer
Cholesterol
Diabetes
Digestive
Ears/Nose/Throat
Endocrine
Eczema/Rashes
Fatigue
Fevers
Genitourinary
High Blood Pressure
Integumentary (Skin)
Kidney
Muscle/Bone
Neurological
Psychological
Respiratory
Sinus
Throat Infections
Thyroid
Unusual weight losses/gains

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

I authorized and request my insurance company to pay directly to the eye doctor any insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependents behalf. If my insurance company has not reimbursed this office in full within 90 days I will be billed directly.

I certify that I have read and understand the above information to the best of my knowledge. I authorize the eye doctor to release any information including the diagnosis and records of any treatment or examination, rendered to me or my child during the period of such eye care, to third party payers and/or health practitioner.

Signature_____